CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, or course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____

Patient's Signature Date

SIGNATURE OF FILE

Please fill out the following and sign below

Do you have insurance?_____

If yes, what kind of insurance do you have? _____

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my insurance companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

Name _____ Medicare # _____
(please print)

Signature _____ Date _____

PRACTICE'S REQUIREMENTS

The Practice:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with the Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
c) Is required to abide by the terms of the Privacy Notice.
d) Reserves the right to change the terms of this Privacy Notice and to make the Privacy Notice provisions effective for all of your PHI that it maintains.
e) Will distribute any revised Privacy Notice to you prior to implementation.
f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/2003

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Signature:_____

Date: _____